FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035006

Facility Name: St Patrick's Residence

Address: 1400 Brookdale Rd (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: 630 416-6565 **Fax #** 630 416-1364

IDPA ID Number: 36-2527011001

Date of Initial License for Current Owners: 03/07/1965

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Robert A. Gancarz **Telephone Number:** 630 753-1502

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 04/30/2003 (Date)
(Type or Print Name) Sister Ann McCartney
(Title) Asst. Administrator/Treasurer

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5	22	Sheltered Care (SC)	22	8,030	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	856	11,197	2,895	14,948	8
9	SNF/PED					9
10	ICF	38,349	13,628		51,977	10
11	ICF/DD					11
12	SC	4,353	3,304		7,657	12
13	DD 16 OR LESS					13
14	TOTALS	43,558	28,129	2,895	74,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.30%

D. How many bed-hold days during this year were paid by Public Aid?
271 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/22/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/22/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 2,895

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/2002 Fiscal Year: 12/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	608,749	54,784	45,519	709,052		709,052	(29,113)	679,939			1
2	Food Purchase		408,311		408,311		408,311	(6,594)	401,717			2
3	Housekeeping	413,849	55,523		469,372		469,372	(22,698)	446,674			3
4	Laundry	192,516	26,916	806	220,238		220,238	(12,716)	207,522			4
5	Heat and Other Utilities			201,532	201,532		201,532	(9,432)	192,100			5
6	Maintenance	221,227	26,708	25,309	273,244		273,244	16,776	290,020			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,436,341	572,242	273,166	2,281,749		2,281,749	(63,777)	2,217,972			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,671,120	203,470	2,375,717	5,250,307		5,250,307		5,250,307			10
10a	Therapy	129,951	6,569		136,520		136,520		136,520			10a
11	Activities	162,520	3,600	4,088	170,208		170,208		170,208			11
12	Social Services	182,556			182,556		182,556		182,556			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,146,147	213,639	2,397,805	5,757,591		5,757,591		5,757,591			16
	C. General Administration											
17	Administrative	248,506		39,270	287,776		287,776		287,776			17
18	Directors Fees											18
19	Professional Services			110,783	110,783		110,783		110,783			19
20	Dues, Fees, Subscriptions & Promotions			74,171	74,171		74,171	(3,073)	71,098			20
21	Clerical & General Office Expenses	225,489	28,359	15,804	269,652		269,652	(35,049)	234,603			21
22	Employee Benefits & Payroll Taxes			924,412	924,412		924,412	(13,117)	911,295			22
23	Inservice Training & Education			2,520	2,520		2,520		2,520			23
24	Travel and Seminar			4,661	4,661		4,661	(1,527)	3,134			24
25	Other Admin. Staff Transportation			4,287	4,287		4,287		4,287			25
26	Insurance-Prop.Liab.Malpractice			143,376	143,376		143,376	(5,928)	137,448			26
27	Other (specify):*											27
28	**TOTAL General Administration**	473,995	28,359	1,319,284	1,821,638		1,821,638	(58,694)	1,762,944			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,056,483	814,240	3,990,255	9,860,978		9,860,978	(122,471)	9,738,507			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Patrick's Residence #0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			583,486	583,486		583,486		583,486			30
31	Amortization of Pre-Op. & Org.			7,667	7,667		7,667		7,667			31
32	Interest			271,613	271,613		271,613	(70,302)	201,311			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			862,766	862,766		862,766	(70,302)	792,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		315,965	346,226	662,191		662,191		662,191			39
40	Barber and Beauty Shops	52,637	614	3,396	56,647		56,647	(65,170)	(8,523)			40
41	Coffee and Gift Shops							(38,614)	(38,614)			41
42	Provider Participation Fee			100,868	100,868		100,868		100,868			42
43	Other (specify):*	71,288		75,186	146,474		146,474	(146,474)				43
44	**TOTAL Special Cost Centers**	123,925	316,579	525,676	966,180		966,180	(250,258)	715,922			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,180,408	1,130,819	5,378,697	11,689,924		11,689,924	(443,031)	11,246,893			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(70,302)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,090)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,392)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(82,822)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (82,822)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (172,214)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Patrick's Residence

ID# 0035006

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Investment Expense	$ (13,274)	21	1
2	Development Salary	(71,288)	43	2
3	Development Expense	(22,383)	43	3
4	Fund Raising Expenses	(51,888)	43	4
5	Barber & Beauty Income	(65,170)	40	5
6	Coffee & Vending Income	(38,614)	41	6
7	Stamp Income	(1,210)	21	7
8	Happy Hor Expense	(1,475)	21	8
9	Public Relations	(915)	43	9
10	Undocumented Travel & Seminar Expense	(1,527)	24	10
11	Promotional Advertising	(3,073)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(270,817)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	(29,113)	0	0	0	0	0	0	0	0	0	(29,113)	1
2	Food Purchase	0	(6,594)	0	0	0	0	0	0	0	0	0	(6,594)	2
3	Housekeeping	0	(22,698)	0	0	0	0	0	0	0	0	0	(22,698)	3
4	Laundry	0	(12,716)	0	0	0	0	0	0	0	0	0	(12,716)	4
5	Heat and Other Utilities	0	(9,432)	0	0	0	0	0	0	0	0	0	(9,432)	5
6	Maintenance	0	16,776	0	0	0	0	0	0	0	0	0	16,776	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(63,777)	0	0	0	0	0	0	0	0	0	(63,777)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,073)	0	0	0	0	0	0	0	0	0	0	(3,073)	20
21	Clerical & General Office Expenses	(35,049)	0	0	0	0	0	0	0	0	0	0	(35,049)	21
22	Employee Benefits & Payroll Taxes	0	(13,117)	0	0	0	0	0	0	0	0	0	(13,117)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,527)	0	0	0	0	0	0	0	0	0	0	(1,527)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(5,928)	0	0	0	0	0	0	0	0	0	(5,928)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(39,649)	(19,045)	0	0	0	0	0	0	0	0	0	(58,694)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,649)	(82,822)	0	0	0	0	0	0	0	0	0	(122,471)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(70,302)	0	0	0	0	0	0	0	0	0	0	(70,302)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(70,302)	0	0	0	0	0	0	0	0	0	0	(70,302)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(65,170)	0	0	0	0	0	0	0	0	0	0	(65,170)	40
41	Coffee and Gift Shops	(38,614)	0	0	0	0	0	0	0	0	0	0	(38,614)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(146,474)	0	0	0	0	0	0	0	0	0	0	(146,474)	43
44	**TOTAL Special Cost Centers**	(250,258)	0	0	0	0	0	0	0	0	0	0	(250,258)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(360,209)	(82,822)	0	0	0	0	0	0	0	0	0	(443,031)	45

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Carmelite Sisters	100.00	None		Carmelite System	Germantown, NY	Religious Order

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 29,113	Carmelite Sisters of the Aged and Infirm		$	$ (29,113)	1
2	V	2	Food Purchase	26,774	Carmelite Sisters of the Aged and Infirm		20,180	(6,594)	2
3	V	3	Housekeeping	22,698	Carmelite Sisters of the Aged and Infirm			(22,698)	3
4	V	4	Laundry	12,716	Carmelite Sisters of the Aged and Infirm			(12,716)	4
5	V	5	Utilities	17,532	Carmelite Sisters of the Aged and Infirm		8,100	(9,432)	5
6	V	6	Maintenance	27,864	Carmelite Sisters of the Aged and Infirm		44,640	16,776	6
7	V	22	Employee Benefits	13,117	Carmelite Sisters of the Aged and Infirm			(13,117)	7
8	V	26	Insurance	5,928	Carmelite Sisters of the Aged and Infirm			(5,928)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 155,742			$ 72,920	$ * (82,822)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Naperville-Usbank		X	Mortgage		12/19/98	$ 6,820,000	$ 5,450,000	01/01/2013	0.0491	$ 271,613	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,820,000	$ 5,450,000			$ 271,613	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,820,000	$ 5,450,000			$ 271,613	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Patrick's Residence COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035006

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 118,218 B. General Construction Type: Exterior CMV Block & Brick Frame Pre-Cast Concrete Number of Stories Three

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 116,922
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 7,667
4. Dates Incurred: 1997

Nature of Costs: Bond Issuance Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	7.33 Acres	1987	$ 638,590	1
2					2
3	TOTALS	7		$ 638,590	3

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210		1989	1989	$ 7,786,645	$ 275,943	25-40	$ 275,943	$	$ 3,756,372	4
5			1997	1997	2,194,676	54,867	40	54,867		301,768	5
6			2000	2000	2,987,034	74,675	40	74,675		127,124	6
7											7
8											8
	Improvement Type**										
9	Land Improvement-Bushes/Shrubs			1990	10,000		10			10,000	9
10	Land Improvements-Asphalt Paving			1990	118,000	7,867	15	7,867		107,513	10
11	Land Improvements-Asphalt Paving			1993	13,251		5			13,251	11
12	Land Improvements-Trees			1993	9,351	935	10	935		9,044	12
13	Land Improvements-Flag Pole			1994	1,501	75	20	75		642	13
14	Land Improvements-Trees and Bushes			1997	40,600	2,030	20	2,030		11,165	14
15	Land Improvements-Trees			1998	3,022	151	20	151		680	15
16	Land Improvements-Asphalt Paving			2000	6,838	342	20	342		855	16
17	Building Improvement-Awning			1991	4,862	324	15	324		3,889	17
18	Building Improvement-Doors			1993	6,175	618	10	618		5,638	18
19	Building Improvement-Windows			1994	2,172	144	15	144		1,312	19
20	Building Improvement-Closets			1994	15,306	1,020	15	1,020		8,681	20
21	Building Improvement-Main Dining Room			1994	13,345	996	15	996		11,436	21
22	Building Improvement-Beauty Shop			1996	2,417	242	10	242		1,631	22
23	Building Improvement-Business Office			1996	559		5			559	23
24	Building Improvement-Smoke Alarms			1997	9,000	900	10	900		9,000	24
25	Building Improvement-Business Office			1997	1,966	197	10	197		1,966	25
26	Building Improvement-Building Plaque			1997	1,000	100	10	100		1,000	26
27	Building Improvement-Stained Glass			1998	14,500	363	40	363		1,631	27
28	Building Improvement-Magnetic Door			1998	4,949	495	10	495		2,227	28
29	Building Improvement-Mortar Repair			1998	5,744	574	10	574		2,585	29
30	Building Improvement-Outside Sign			1999	3,200	320	10	320		1,120	30
31	Building Improvement-Security System			1999	3,632	363	10	363		1,271	31
32	Building Improvement-Outside Awning			2000	2,398	120	20	120		300	32
33	Building Improvement-Expansion Joint			2000	7,345	367	20	367		918	33
34	Building Improvement-Cooling Pumps			2001	10,440	522	20	522		783	34
35	Building Improvement-Fire Sprinkler Main			2002	3,966	198	10	198		198	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,283,894	$ 424,748		$ 424,748	$	$ 4,394,559	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,205,306	$ 142,147	$ 142,147	$	5 & 10	$ 1,726,302	71
72	Current Year Purchases	101,527	6,999	6,999		5 & 10	6,999	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,306,833	$ 149,146	$ 149,146	$		$ 1,733,301	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1994 Ford Bus	1994	$ 39,951	$ 4,001	$ 4,001	$	10	$ 35,661	76
77	Facility Business	1996 Dodge Pickup	2000	23,116	4,627	4,627		5	11,566	77
78	Facility Business	1999 Pontiac Grand Am	2002	9,717	964	964		5	964	78
79										79
80	TOTALS			$ 72,784	$ 9,592	$ 9,592	$		$ 48,191	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,302,101	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 583,486	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 583,486	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,176,051	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Architectural Costs	$ 61,437	92
93			93
94			94
95		$ 61,437	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 69,866	$		$ 69,866	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			17,507			17,507	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			77,025			77,025	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				312,082		312,082	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule					151,567	34,144		185,711	13
14	TOTAL			$		$ 315,965	$ 346,226		$ 662,191	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 706,260	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 51,939)	1,385,548		3
4	Supply Inventory (priced at Cost)	31,553		4
5	Short-Term Investments	1,740,739		5
6	Prepaid Insurance	99,334		6
7	Other Prepaid Expenses	31,232		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Pledge Receivable	460,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,454,666	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost	13,081,268		14
15	Leasehold Improvements, at Historical Cost	202,563		15
16	Equipment, at Historical Cost	2,379,617		16
17	Accumulated Depreciation (book methods)	(6,176,051)		17
18	Deferred Charges	61,437		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Pledge Recevable	2,440,000		22
23	Other(specify): Bond Issuance Costs	78,007		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,705,431	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,160,097	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 853,185	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	366,813		30
31	Accrued Taxes Payable (excluding real estate taxes)	326		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	136,771		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	60,450		36
37		3,208		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,420,753	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,450,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		27,296		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,477,296	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,898,049	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,262,048	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,160,097	$	48

***(See instructions.)**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,732,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,732,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,502,272	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	27,253	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,529,525	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,262,048	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,765,026	1
2	Discounts and Allowances for all Levels	(2,710,351)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,054,675	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	656,898	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 656,898	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	38,614	12
13	Barber and Beauty Care	65,170	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	23,680	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,699	19
20	Radiology and X-Ray	35,423	20
21	Other Medical Services	92,120	21
22	Laundry	3,635	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 263,341	23
	D. Non-Operating Revenue		
24	Contributions	3,283,487	24
25	Interest and Other Investment Income***	70,302	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,353,789	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain(loss) on Investments	(141,072)	28
28a	Gain on disposal of Asset	4,565	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (136,507)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,192,196	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,281,749	31
32	Health Care	5,757,591	32
33	General Administration	1,821,638	33
	B. Capital Expense		
34	Ownership	862,766	34
	C. Ancillary Expense		
35	Special Cost Centers	865,312	35
36	Provider Participation Fee	100,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,689,924	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,502,272	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,502,272	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,450	$ 59,470	$ 24.27	1
2	Assistant Director of Nursing	2,132	2,332	59,113	25.35	2
3	Registered Nurses	25,012	25,562	623,762	24.40	3
4	Licensed Practical Nurses	15,739	17,340	381,029	21.97	4
5	Nurse Aides & Orderlies	100,536	108,751	1,474,609	13.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,080	2,240	50,245	22.43	7
8	Rehab/Therapy Aides	3,831	4,261	79,706	18.71	8
9	Activity Director	2,080	2,200	28,723	13.06	9
10	Activity Assistants	9,166	9,794	133,797	13.66	10
11	Social Service Workers	11,613	12,392	182,556	14.73	11
12	Dietician	1,960	2,160	51,142	23.68	12
13	Food Service Supervisor	5,696	6,332	88,656	14.00	13
14	Head Cook	3,814	4,264	66,818	15.67	14
15	Cook Helpers/Assistants	3,846	4,398	48,137	10.95	15
16	Dishwashers	38,841	43,781	353,996	8.09	16
17	Maintenance Workers	14,628	16,042	221,227	13.79	17
18	Housekeepers	43,853	48,570	439,931	9.06	18
19	Laundry	17,798	20,111	166,434	8.28	19
20	Administrator	2,160	2,280	67,770	29.72	20
21	Assistant Administrator	2,160	2,280	58,855	25.81	21
22	Other Administrative	1,960	2,160	56,537	26.17	22
23	Office Manager	2,030	2,270	65,344	28.79	23
24	Clerical	12,715	14,998	225,489	15.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	5,332	5,862	73,137	12.48	32
33	Other(specify) Dvlpmt/Beauty	6,510	7,002	123,925	17.70	33
34	TOTAL (lines 1 - 33)	337,572	369,832	$ 5,180,408 *	$ 14.01	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	96	4,356	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,320	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,549	10-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	125	$ 25,225		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	27,895	$ 1,129,773	10-3	50
51	Licensed Practical Nurses	5,500	204,868	10-3	51
52	Nurse Aides	50,507	1,035,400	10-3	52
53	TOTAL (lines 50 - 52)	83,902	$ 2,370,041		53

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sister Anthony	Administrator		$ 67,770
Sister Jeanne	Asst Admnstrtr		58,855
Robert Gancarz	Controller		65,344
Ken Deardorff	HR Director		56,537
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 248,506

B. Administrative - Other

Description	Amount
Carmelite System Dues	$ 39,270
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 39,270

C. Professional Services

Vendor/Payee	Type	Amount
PriceWaterhouseCoopers	Auditing	$ 30,000
Frost, Ruttenberg & Rothblatt	Medicare Consulting	6,805
Katten, Muchin & Zavis	Legal	32,275
Michael, Best & Friedrich	Legal	12,767
CHCS	Survey Consulting	10,400
Practical System Solutions	Computer Consulting	7,459
Margolis, Marmel & Crosby	Tax Consulting	3,352
Radius Consulting Group	Medicaid Consulting	3,075
Systematic Mgmt Systems	Part B Billing	2,500
Method Management	Survey Consultant	1,250
MindGent	Network Consultant	900
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 110,783

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,000
Unemployment Compensation Insurance	9,300
FICA Taxes	360,216
Employee Health Insurance	325,046
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	37,504
Pension	81,550
Staff Development	6,093
Employee Physicals & vaccinations	2,703
TOTAL (agree to Schedule V, line 22, col.8)	$ 924,412

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	47,472
Health Care Worker Background Check	1,628
(Indicate # of checks performed 230)	
Association Fees	9,341
Dues and Subscriptions	12,657
Promotional Advertising	3,073
Less: Public Relations Expense	( )
Non-allowable advertising	(3,073)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 71,098

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $9,341**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **108,654** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **100,868**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Frost, Ruttenberg & Rothblatt** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number Saint Patrick's Residence # 0035006 Report Period Begin 1/1/2002 Ending ########

Cost Center Expenses (Schedule V.)
Other Expense-Line 43

Column	Description	Amount	Total
1	Development Salary	$ 71,288	
			$ 71,288
3	Development Expense	$ 22,383	
3	Fund Raising Expense	51,888	
3	Public Relations	915	
			$ 75,186

Board of Directors Listing

Bishop Joseph L. Imesch

Reverend Joel Fortier

Sister Ann Elizabeth Brown, O.Carm

Sister M. Teresa Stephen Pereira, O.Carm

Sister M. Paul Anthony Videtich, O.Carm

Sister Norah Michael McNamara, O.Carm

Sister Mary Rose Heery, O.Carm

Mr. John J. Durso

Mrs. Nancy L. Gorman

Mr. Raymond E. Jones

Miss Josephine Mancuso

Mr. Frank G. Slocumb

Special Services(Schedule XIV.)

Supplemental Schedule of Medical Supplies
Line 13

Supplies (column 6)	$ Amount
1-X-Ray Services	$ 27,450
2-EKG Services	6,694
Total 39-3	$ 34,144

Outside Practioner (column 5)	$ Amount
1-Medicare Part A Therapies	$ 151,567
Total 39-2	$ 151,567

Facility Name & ID Number	Saint Patrick's Residence	# 0035006	Report Period Begin	1/1/2002	Ending	########